Optum

Evaluation and Management Coding Advisor

Advanced guidance on E/M code selection and documentation

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Contents

How to Use *Evaluation and Management Coding Advisor*

To identify a particular E/M code, select an E/M level of service code from the CPT book. Next, locate this code in the E/M code types section of *Evaluation and Management Coding Advisor*.

The subsections within E/M code types are in numeric order according to the CPT book, and most subsections contain the following information:

- Quick comparison
  - at-a-glance chart for a quick review of all of the codes in that particular CPT code series and associated decision making, history, and exam requirements
- General guidelines
  - instructional notes for correct E/M code assignment within subset
- Common issue
  - outlines questions frequently associated with a code range or single code
- Documentation requirements
  - medically appropriate history
  - medically appropriate physical examination
  - medical decision making (MDM)
    - number and complexity of problems
    - amount and/or complexity of data reviewed and analyzed
    - risk of complications/morbidity or mortality
  - total time spent on the date of the encounter
    Note: For total time, counseling and coordination of care dominating more than 50 percent of the encounter is no longer a requirement. Time for these services includes total face-to-face and non-face-to-face time spent by the provider on the date of the encounter.
- Sample documentation
  - real-life clinical vignettes to assist in verifying the level of service and medical necessity for each CPT code in the series.
  - textbook- style notes, as well as samples, when practical, that provide a more real-life style of documentation

Review the coding and documentation requirements for the code selected. If the medical decision making documented in a chart being reviewed does not match the levels required for that particular code, locate a more appropriate code by reviewing the quick comparison chart or the code detail of the next code, higher or lower.

Note: Some sections may also contain additional information or instruction from a Medicare contractor, CMS, or other agency titled under the header "Special Instructions" or "Special Notice."

Follow these steps to validate medical documentation in a chart being reviewed

1. **Identify the MDM components in the medical record documentation (see the following example).**
2. **Select an E/M code from the CPT code book based on the MDM components, place and/or type of service, and/or time.**
3. **Review in the E/M code types section the documentation requirements and samples of documentation for the code selected.**

If the documentation does not include all of the necessary components to support the level of E/M code that has been chosen, it may be necessary for the physician/qualified health care professional to complete the chart note with correct details of the patient encounter, if appropriate, or select the documented E/M code for billing purposes.

Correcting documentation in "real time" is generally accepted; late entries for the purpose of filling documentation gaps to support billing a particular code level is not. If it takes a few charts being billed at a lower code level based on missing or insufficient documentation to get a provider's attention, this may prove a good lesson in the long run. The goal should be to teach the provider to recognize the key elements of services as they are provided and be certain that they are documented in the normal course of documentation.

Quick Tip

Review the practices policy for correcting documentation or creating an addendum.

Check for additional instructions under "General Guidelines," or situations that may be relevant in the common issues section. Such instructions include whether a modifier is necessary or what information may need to be reported separately. Consult the provider if chart documentation may not support medical necessity for services. While medical necessity is based on the judgment of the clinician, the chart documentation must clearly support the need for services provided.

Chapter 3. The Building Blocks of E/M Coding

The levels of evaluation and management (E/M) services define the wide variations in skill, effort, time, and medical knowledge required for preventing or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent provider work—mostly cognitive work. Because much of this work revolves around the thought process, and involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code appears to be complex, but the system of coding medical visits is actually fairly simple once the requirements for code selection are learned and used.

Objectives

This chapter discusses:

- **Determining levels of evaluation and management (E/M) services using MDM or time**
- **Definitions of E/M services and the current E/M documentation guidelines**
- **Modifiers used with E/M codes**

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified.

The place of service and service type is defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

Categories of E/M Services

Codes for E/M services are categorized by the place of service (e.g., office or hospital) or type of service (e.g., critical care, preventive medicine services). Many of the categories are further divided by the status of the medical visit (e.g., new vs. established patient or initial vs. subsequent care).

New and Established Patients

A **new patient** is defined by the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) as one who has *not* received any professional services from a provider or other qualified health care professional (OQHP) of the exact same specialty and subspecialty from the same group practice within the last three years. An **established patient** is defined as one who *has* received a professional service from a provider or OQHP of the exact same specialty and subspecialty from the same group practice within the last three years. If the patient is seen by a physician or OQHP who is covering for another physician or OQHP, the patient will be considered the same as if seen by the physician or OQHP who is unavailable.

Initial and Subsequent Services

An **initial** service is defined by the AMA as one who has *not* received professional services from a provider or OQHP of the exact same specialty and subspecialty from the same group practice during an inpatient, observation, or nursing facility admission. A **subsequent** service is defined as one who *has* received professional services from a provider or OQHP of the exact same specialty and subspecialty from the same group practice, during an inpatient, observation, or nursing facility admission. If the patient is seen by a physician or OQHP who is covering for another physician or OQHP, the patient will be considered the same as if seen by the physician or OQHP who is unavailable.

Note: Per the CY2023 Physician Fee Schedule Final Rule, CMS adopted these definitions with one exception. CMS does not recognize subspecialties and has left "subspecialty" out of their definitions.

Over-Documenting the Encounter

Providers who are unfamiliar with EHR templates or are not fully trained may consider the template to be a "mandatory" list of check boxes that all must be completed. The documentation templates need to be completed so that the higher level of E/M service can be captured and documented. However, providers should perform only as much history, exam, and decision making as is necessary for appropriate treatment of the presenting problem. Over-documenting on a template uses provider time performing and documenting unnecessary components.

This is reiterated by CMS in the *Medicare Claims Processing Manual,* Pub. 100-04, chapter 12, section 30.6:

- Medical necessity of a service is the "overarching criterion" for payment in addition to the individual requirements as defined by the CPT code nomenclature
- It is not medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted
- Sheer volume of documentation is not a factor for selecting a specific level of service

Under the 1995 and 1997 E/M guidelines, the sheer volume of documentation was often felt to support a higher level of E/M code. With the changes to E/M codes in 2021 and 2023, the emphasis is not on the volume of documentation but content.

Providers must still document appropriate history and exam, but focus is no longer on counting specific elements of the history and exam. Rather than completing a template, many providers will revert back to free-form text to report the encounter. The documentation must still reflect the services rendered and provide a record for continuity of care and support of the medical decision making. Detail of the history and exam performed is more beneficial than simply stating the patient returns for follow-up. Although the detailed template may not be used, details such as chief complaint, changes to history, and exam are still useful elements in treating the patient and supporting the medical decision making.

Key Point

The E/M guidelines state: The extent of history and/or physical examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s)."

The medical decision making documentation should identify the three elements and support a final level of complexity. Identification of problems addressed includes signs and symptoms where a final diagnosis may not be made, as well as other coexisting conditions and possible complications. The data reviewed should be documented including laboratory results, pathology reports, radiology exams, patient monitoring, and all other data pertinent to diagnosing and treating the patient. The patient risk, including monitoring of medications and treatment, possible complications, or other factors should also be noted.

Documentation should still present a "snapshot" of the encounter that supports the testing and treatment, level of care, and provides information for other providers who may participate in the patient care.

Signatures

Complying with payers' signature guidelines is vital, especially when a practice is audited. CMS has modified its signature guidelines several times over the years. These guidelines not only apply to providers, but they serve as a reference for medical reviewers when reviewing medical records and claim documentation.

If a signature is illegible, practices may choose to use a signature log (a list of the typed or printed name of the author associated with initials or illegible signatures) or an attestation statement to determine the identity of the author of a medical record entry.

If a signature is missing from the medical record, an attestation statement may be completed. Below is an example of a CMS approved attestation statement:

"I, _____[**print full name of the physician/practitioner**], hereby attest that the medical record entry for _____**[date of service]** accurately reflects signatures/notations that I made in my capacity as _____**[insert provider credentials, e.g., M.D.]** when I treated/diagnosed the above-listed Medicare beneficiary. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and that I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Providers should avoid adding late signatures to the medical record (beyond the short delay that occurs during transcription) but instead use the signature attestation. The signature attestation can also be used for illegible signatures.

Chapter 6. Office or Other Outpatient Services (99202–99215)

New Patient (99202–99205)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99202	Straightforward	Medically appropriate	Medically appropriate	15 min.
99203	Low	Medically appropriate	Medically appropriate	30 min.
99204	Moderate	Medically appropriate	Medically appropriate	45 min.
99205	High	Medically appropriate	Medically appropriate	60 min.

General Guidelines

- Code selection is based on MDM or total time, including face-to-face and non-face-to-face time spent on the date of the encounter.
- History and physical examination elements are not required for code level selection for office and other outpatient services. However, a medically appropriate history and/or physical examination should still be documented. The nature and degree of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.
- Clinical staff may collect information pertaining to the history and exam and the patient and/or caregiver may provide information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting provider.
- Total time for these services includes total face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the day of the encounter.

Quick Tip

Medical necessity is still the overarching criterion for selecting a level of service in addition to the individual requirements of the E/M code.

- Physician or other qualified health care professional time may include the following activities:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other health care professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)

Key Point

A "results" only test that does not require separate interpretation, but is analyzed as part of the MDM for the encounter, counts as one ordered/reviewed item under the Data element.

- Comorbidities or other underlying conditions should not be considered when selecting the level of service unless they are addressed during the encounter and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality.
- Use these codes if the patient has not been seen or had a professional service provided by this physician/qualified health care professional or any other physician/qualified health care professional from the same practice and exact same specialty and subspecialty in the past three years.
- Consider using the appropriate critical care code instead of these codes if the physician/qualified health care professional provided constant care to a critically ill patient. Critical care codes are based on the patient's condition, not the site of service, and are selected according to time spent in attending the patient.
- Consider assigning the appropriate consultation code instead of these codes if the provider provided an opinion or advice about a specific problem at the request of another provider or other appropriate source.
- Report only the appropriate initial hospital or observation care or comprehensive nursing facility assessment code if the patient was admitted to the hospital or nursing facility on the same day as another visit.

Chapter 8. Hospital Services (99221–99239)

Hospital Inpatient or Observation Care Services—Initial Care, New or Established Patient (99221–99223)

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99221	Straightforward or low	Medically appropriate	Medically appropriate	40 min.
99222	Moderate	Medically appropriate	Medically appropriate	55 min.
99223	High	Medically appropriate	Medically appropriate	75 min.

General Guidelines

- Code selection is based on MDM or total time, including face-to-face and non-face-to-face time spent on the date of the encounter.

Coding Axiom

Medicare does not accept consultation codes. Use initial hospital care codes to report the first inpatient encounter by a physician. The admitting physician should append modifier AI Principal physician of record, to the initial hospital care code.

- History and physical examination elements are not required for code level selection. However, a medically appropriate history and/or physical examination should still be documented. The nature and degree of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.
- Total time for these services includes total face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the day of the encounter.
- Physician or other qualified health care professional time may include the following activities:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other health care professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)
- Comorbidities or other underlying conditions should not be considered when selecting the level of service unless they are addressed during the encounter and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality.
- Use these codes if the patient has not been seen or had a professional service provided by this physician/qualified health care professional or any other physician/qualified health care professional from the same practice and exact same specialty and subspecialty during the stay.
- Transition from observation status to inpatient care does not constitute a new stay.

Key Point

When determining the amount and/or complexity of data reviewed and analyzed, each unique test ordered is counted once; the review of that test is included within the order.

- Consider using the appropriate critical care code instead of these codes if the physician/qualified health care professional provided constant care to a critically ill patient. Critical care codes are based on the patient's condition, not the site of service, and are selected according to time spent in attending the patient.
- Consider assigning the appropriate consultation code instead of these codes if the provider provided an opinion or advice about a specific problem at the request of another provider or other appropriate source.
- Report only the appropriate initial hospital or observation care, or comprehensive nursing facility assessment code if the patient was admitted to the hospital or nursing facility on the same day as another visit.
- Do not include the time spent by any other staff (e.g., nurse, nurse practitioner or physician assistant) toward the time thresholds. Face-to-face and non-face-to-face time is the time the treating provider spent on the date of the encounter.
- A service that spans two calendar dates is a single service and is reported on one calendar date. For Medicare, report the date the encounter starts and select a code that encompasses all the services provided, including admission and discharge.

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Documentation Requirements

Medical Decision Making: Moderate
- Moderate number and complexity of problems addressed
- Moderate amount and complexity of data reviewed and analyzed
- Moderate risk of complications and/or morbidity or mortality

History: Medically appropriate

Examination: Medically appropriate

Code Indicators (from the MDM table)

Number and Complexity of Problem(s)
- One or more chronic illnesses with exacerbation, progression, or side effects of treatment
- Two or more stable chronic illnesses
- One undiagnosed new problem with uncertain prognosis
- One acute illness with systemic symptoms
- One acute, complicated injury

Amount and/or Complexity of Data
**Each unique test, order, or document contributes to the combination of two or combination of three in Category 1 below.*
- Moderate

(Must meet the requirements of at least one of the three categories.)

Category 1: Tests, documents, or independent historian(s)
- Any combination of three from the following:
  - review of prior external note(s) from each unique source*
  - review of the result(s) of each unique test*
  - ordering of each unique test*
  - assessment requiring an independent historian(s)

  or

Category 2: Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

  or

Category 3: Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

Risk of Complications/Morbidity or Mortality
Moderate risk of morbidity from additional diagnostic testing or treatment

Examples only:
- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health

Chapter 19. HCPCS G Codes and Evaluation and Management Services

Medicare Covered Care Plan Oversight Services (G0179–G0182)

HCPCS Code	Medicare Covered CPO Services	Place of Service	Under Care of	Presence of Patient	Time
G0179	Physician recertification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per recertification period	In home, a domiciliary or equivalent environment (e.g., Alzheimer's facility)	Home health agency	Patient not present	N/A
G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per recertification period	In home, a domiciliary or equivalent environment (e.g., Alzheimer's facility)	Home health agency	Patient not present	N/A
G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	In home, a domiciliary or equivalent environment (e.g., Alzheimer's facility)	Home health agency	Patient not present	30 min. or more
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	Hospice	Hospice	Patient not present	30 min. or more

General Guidelines

- Care plan oversight (CPO) is physician, or other qualified health care provider, supervision of patients receiving either home health or hospice benefits where complex or multidisciplinary care modalities and ongoing provider involvement are required.
- CMS extended Medicare coverage to allow separate payment for CPO services of or exceeding 30 minutes per month for patients who are receiving Medicare-covered home health or hospice benefits.
- Medicare does not pay for CPO services for nursing facility or skilled nursing facility patients.
- Code descriptors for these codes include communication with family member(s), surrogate decision maker(s) (e.g., legal guardians) and/or key caregivers as well as health care professionals.
- Only one provider, per month, will be paid for CPO services for a patient.
- Codes 99374–99378 are not covered under Medicare. These services should be reported to Medicare with codes G0181 and G0182.
- Care plan oversight provided to Medicare patient's for home health or hospice care plan oversight services are reported with HCPCS Level II codes G0181–G0182.
- Care plan oversight for certification and recertification of home health services are reported with HCPCS Level II codes G0179–G0180.
- Home health certification includes creation of a plan of care and verification that the home health agency complies with the written plan of care.
- The physician must maintain awareness of a patient's ongoing needs and of changes in the patient's condition or medications.

Chapter 20. Coding and Compliance

Ongoing Compliance Investigations

E/M Service	Compliance Issue	Investigating Agency
E/M codes reported during the global period	E/M services bundled into the global surgical package not provided	Office of Inspector General (OIG), recovery audit contractors (RAC)
Use of modifiers during the global surgery period	Modifiers used inappropriately to report E/M services that are bundled into the global surgical package	Office of Inspector General (OIG),
Initial preventive physical examination (IPPE)	Misuse due to the likelihood that non-Medicare patients may have already received the preventive services listed under the IPPE	Office of Inspector General (OIG), recovery audit contractors (RAC)
Assigning new patient E/M codes	More than one new patient E/M service reported for the same beneficiary within a three-year period	Recovery audit contractors (RAC)
High level subsequent nursing facility care codes	Higher levels of care reported but not supported by documentation	Centers for Medicare and Medicaid Services (CMS), Medicare Administrative Contractor (MAC)—National Government Services (NGS)
Anesthesia care package and billing E/M codes separately	Unbundling of E/M services in anesthesia claims	Recovery audit contractors (RAC)
Critical care and emergency department (ED) services	Inappropriate use of critical care codes	Office of Inspector General (OIG), Recovery audit contractors (RAC)
Pulmonary diagnostic procedures with E/M services	Overpayments associated with E/M services and diagnostic pulmonary procedures	Recovery audit contractors (RAC)

E/M Codes Reported During the Global Period

General Guidelines

- CMS established a national definition for a global surgical package to ensure consistent payment for the same services across all carrier regions.
- CMS defined the global surgical package to include:
  - preoperative visits
  - intraoperative services
  - complications following surgery
    - does not require a return trip to the operating room
  - postoperative visits related to recovery
  - postsurgical pain management provided by the surgeon
  - certain supplies
  - miscellaneous services, including:
    - dressing changes
    - local incisional wound care
    - removal of packing material
    - removal of sutures, staples, wires, lines, tubes, drains, casts, and splints
    - insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes
    - changes and removal of tracheostomy tubes
- In determining global surgery fees, CMS estimates the number of E/M services a physician provides to a typical beneficiary during the surgery period; physicians are compensated for the surgical service and related E/M services regardless of the number of E/M services actually provided during the global surgery period.
- Postoperative periods that apply to each surgical procedure are provided in the Medicare Physician Fee Schedule Data Base (MPFSDB). Payment rules for surgical procedures apply to codes with postoperative periods of 000, 010, 090, and sometimes YYY.
- Major surgeries include one day preceding the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.
- Minor surgeries include the day of surgery and the appropriate number of days immediately following the day of surgery.

Chapter 21. Knowledge Assessments with Answers

Chapter 2 Questions and Answers

1. How is using a documentation method beneficial?
   a. Using a standardized documentation format expedites the revenue cycle process
   b. Using a standardized documentation format ensures a lower medical malpractice premium
   c. Using a standardized documentation format can help decrease audit liability
   d. Using a standardized documentation format has not been proven to be beneficial

   Rationale: Standardized documentation formats not only decrease audit liability by consistently and uniformly establishing medical necessity and ensuring that all of the appropriate elements are documented but they also help to promote continuity of care and quality of care. When all elements are regularly and reliably documented, the likelihood of omissions and errors greatly diminish and, furthermore, clinicians become more confident and comfortable in their documentation. More detailed, consistent, thorough documentation ensures more appropriate, accurate, and timely billing.

2. Why are E/M services considered the dominant source of revenue for most providers?
   a. They are among the most frequently billed services
   b. They have high reimbursement values
   c. Providers can bill all high levels of care
   d. These services are not monitored

   Rationale: Although the reimbursement amount for E/M services is considered relatively low in comparison to surgical services, the volume of E/M services performed makes them a significant source of revenue for most providers.

3. What can providers use to assess overall coding patterns?
   a. Reimbursement rates from payers
   b. Coder productivity
   c. Payer requests for documentation
   d. Benchmark data

   Rationale: Using E/M benchmark data can help providers analyze patterns of use for specific E/M codes.

4. Which modifier should be reported to indicate to a payer that service was provided via synchronous telemedicine?
   a. 25
   b. 57
   c. 95
   d. 97

   Rationale: CPT® modifier 95, effective January 1, 2017, is to be appended to certain CPT codes designated as synchronous telemedicine services, identified in the CPT book with a star symbol [★]. A list of applicable CPT codes for reporting real time telehealth services with modifier 95 can be found in appendix P of the CPT book.

Appendix A. Physician E/M Code Self-Audit Forms

Note: For 2025, the forms contained in this appendix will also be available as a downloadable PDF. To access the forms, use the following URL and password: www.optumcoding.com/support/product-updates/ Password: **XXXX**

Evaluation and Management Services Worksheet

The following worksheet may be used to collect the necessary data when auditing a medical record for office and other outpatient services (99202-99205 and 99212-99215).

Note: For definitions and details regarding each MDM element, refer to chapters 3 to 11 of this publication.

Example 1: Office and Other Outpatient Services Audit Worksheet

Record Number				DOS billed	
Attending		Signed ❑ Yes ❑ No		DOS Rendered	
E/M Billed	**E/M Documented**		**E/M Mod Billed**	**E/M Mod Doc**	
Incident to:					
When a yes is answered for **all** of the following, the service may be billed as incident to under Medicare guidelines.				**Yes**	**No**
Is the NPP an employee of the practice?				❑	❑
If this is a new patient, did the physician participate in the patient's care?				❑	❑
Was direct personal supervision by the physician provided for in-office encounters?				❑	❑
Does the physician have an active part in the ongoing care of the patient?				❑	❑
History	Was a medically appropriate history documented?			Yes ❑	No ❑
Examination	Was a medically appropriate exam documented?			Yes ❑	No ❑